THE BRUSH-UP

News of Boulder River School and Hospital

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Learning Center Opens

COTTAGE 6: TRANSFORMATION OF AN ABANDONED RESIDENTIAL UNIT INTO A RESIDENTIAL LEARNING CENTER!
by Tom Seekins

Less than a year ago, Cottage 6 was an open residential living area. Both men and women lived within extensive day-halls, wards and hallways. The main exit outside the cottage was constantly locked.

The building was closed to residential living in the summer of 1976 and the Administration immediately began considering different uses for it. One idea was to transform its empty and gutted shell into training areas. By November 1976, it was decided that the Communications Department and Title I would centralize their services in Cottage 6.

This centralization of services and staff was seen as capable of providing many benefits: A) an increased rate of interaction between the professional and para-professional staff; B) greater interchange of ideas; C) easier transportation of residents; D) more expected hours of training.

Shortly after the move began it was also decided to re-locate the School offices and several of the teachers in Building 6. It was obvious that even more benefits could be derived by having the main portion of three agencies under one roof.

Before the move to Cottage 6, Title I was spread across the grounds in four classroom settings. The classrooms were in Cottage 4, Cabin 64, and Cabin 60. Now two are in Building 6 and a third will be moving as soon as essential repairs are made.

In the past, the Communications Department provided therapy to its clients by going out into the various areas, finding clients and conducting therapy sessions. Some sessions were given in Building 8 and some in Cabin 65 but now the entire Communications Department is located in Building 6. Other activities to be located in the building include functional academics, living skills and deaf education.

Well over half the residents in the institution will pass through one or more of the classrooms in Building 6 during a given day. Communications and Title I, alone, have 134 residents scheduled each day.

Training, therapy, and classes are scheduled from 8:30 to 11:30 in the morning and from 12:30 to 3:45 in the afternoon; just over six hours a day. Visitors from the cottages are almost always welcome to come and observe classes in which residents who are in their charge participate. Observation facilities (one-way mirrors), will soon be available so that there will be no fear of interruption.

Department News

Administrative Support

New addition...Fay Fleetham, Accounting Technician I, had a six pound six ounce baby girl on February 3 at 3:08 p.m. She christened the baby a very pretty but unusual name, Delci Autumn. Fay came back to work on February 10th.

Resident Operations

Speaking of babies on December 23rd, Debbie Olson, Research Assistant, gave birth to a big eight pound, eight ounce boy. She named him David Ole Olson.

Felma Herseim assumed her new duties as Supervisor for Administrative Affairs January 17. Felma replaces Ms. Lou Thompson. When asked, Felma said things were going "Just fine".

Barb Schmidt rearranged her corner again. Tom Dolan, Personnel Supervisor, said that unless this process discontinues, he is going to try to get her a job with Allied Van Lines.

Habilitation

On Thursday, January 27, Don Horner gave a talk on The Essential Components of an Instructonal Program. Mr. Horner is associated with the University of Kansas. He spoke to a standing room only crowd in the Building 8 conference room from 2:00 to 4:00 p.m. Later that evening, he attended the SABT meeting.

Five Systematic Intervention Workshops were held for Cottage Supervisors and HA IV's. The purpose was to train Cottage Staff in the systematic method of dealing with behavioral problems in a consistent manner which is in compliance with existing laws and regulations.

The international conference on Behavior Modification will be held in Banff, Alberta, March 20 through 24. Tim Plaska hopes to attend this meeting. Gary Adams hopes to go to the third annual Western Regional Conference about Humanistic Approaches and Behavior Modification which will be held in Las Vegas, Nevada, March 10th through the 12th.

Resident Support

Randy Hosler, former Safety and Security Officer, left January 19th for Minneapolis, Minnesota. Before leaving, he said to give a warm good-bye to all his friends through the Brush-Up.

Sweetheart Ball

The Butte Musicians that provided the music.

There was a banquet and Sweetheart Ball on February 14th, Valentine's Day. According to Marilyn Huestis, Recreation Supervisor, over a hundred and fifty residents from almost all cottages participated. Marilyn wishes to give special thanks to those members of the Butte Musicians Association who donated their time free of charge; the Food Service Department who put in extra work for the banquet and the cottage personnel who worked so hard to see that the residents enjoyed themselves that evening.

Treatment and Evaluation

New People

Mary Jane Spethman was hired as an Administrative Assistant to replace Marilyn Craft. Jane was previously employed in the Planning/Evaluation Section.

Congratulations, also, to Sandy Germer, of the X-Ray Department, who had a baby boy on December 31, 1976. Sandy came back to work on February 17. During her absence, Marjo White, an X-Ray Technician from Helena, was filling in.

In Occupational Therapy, John Collins has recently been hired as an OT Aide. John comes from American Forks, Utah. He was previously employed in the Occupational Therapy Department at the Institution for the Mentally Retarded in Utah.

Becky Petrashek joined the R.N. staff in December. She comes from Wisconsin.

Scott Woodring is now on board as a Speech Pathologist. He came to Boulder from Virginia. A new speech aide, Sue Wirthlin, has been hired. Terry Jones has transferred from Cottage 10 to Title I.

Events

Doctor Robert Fulton of the University of Kansas Medical Center ("Commonly known as the father of operant Audiology"), evaluated the Speech and Audiology Department on January 10th and 11th.

Doctor Judy Northrup, West Yellowstone, a specialist in Physical Medicine, conducted her first consultation at the Hospital on January 19.

Doctor Taubenberger attended a lecture series entitled "Modern Concepts in Epilepsy", at the University of Washington in Seattle on February 4th and 5th. From what he saw and heard at the conference, BRS&H is up to date in all aspects of seizure control.

All the treatment and evaluation and hospital department heads attended a JCAH sponsored workshop on February 14th and 15th to prepare for a complete JCAH survey later this year.

What is Rapport?

By George Chance

Four or more years ago, I grew impatient with what a resident was saying and interrupted his conversation. He gave me a hurt look and I still remember what he said, "Please listen to what I have to say. I have feelings too, you know." I paid him heed and I have always tried since then to fully realize that the people in my charge are human beings, with hopes, love, desires, and hates, just as I have, no matter how severe their retardation.

I opened this article with the preceeding observation because this boy taught me a secret that has helped me greatly in my work as a Physical Education Instructor at the Boulder River School and Hospital. He expressed what I believe is the essential part of rapport, that over-used, much abused, little understood word which is still an important part of the training of the mentally retarded. For, if we can't meet the resident on his ground, not as an inferior, not as a freak, but just another person in need of training and instruction to the best of (I wish there were another word to include both "his and her"), his or her abilities.

Remember, in every block of granite, marble or alabaster is the greatest statue ever carved. Give a person the finest chisels made, the most elaborate studio, the best training, and if he doesn't have the ability to identify himself with the hidden masterpiece, it will never appear. In other words, despite all the scientific approaches, despite the various schools of thought -and they do vary- the training of the retarded is an art, every bit as much as the painting of a landscape, the capture of a fine photograph, or the writing of the great American novel.

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Now, I can't tell you how to develop rapport, because you are you and you must relate to the other person in your way. What is more, each individual you are dealing with has a different personality. I know of one boy in this school who will not respond to me unless I almost literally bark at him. He knows the bark is harmless and if I threaten to pop him on the nose he would laugh because he realizes I would never do such a thing. Yet, the loud, "trainer's voice" is necessary to attract and hold his attention. On the other hand, if I use such an approach with another person, for example a girl I teach, I would lose her entirely, for weeks if not forever.

I can't tell you what rapport, or whatever you want to call it, is, exactly. Perhaps an approximate definition would be "true concern". Webster defines it as "harmonious, sympathetic relationship, accord". In our work, I would add "the ability to communicate and elicit a response".

Whatever rapport is, like a vitamin, it remains a necessary ingredient. It is sort of a leavening factor. Or, as Grandpa used to say "That's what makes the mare go."

Perhaps the above definitions seem vague and fumbling. But then, so would any description of a sunbeam. You either feel it or you don't. It seems to me the easiest way to feel it is to develop a sincere, warm, nonsonsense approach to the instruction of the retarded.

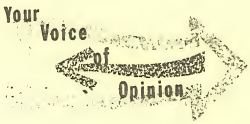
Continuing on, I would say it is easier to tell you what rapport is not, than what it is. It certainly is not the "bleeding heart" approach with a surface emotion and sentimentality, nor is it the purely objective machine-like tack that ignores the fact that the subject has "feelings too". It definitely is not the superior attitude where the instructor addresses the student condescendingly in words of one syllable, and in sentences of two words. It is not the standoffish "stay away from me, you're full of germs" method of teaching where the subject becomes vermin in the eyes of the beholder. It certainly is not the "do nothing" method that assumes the resident is incapable of learning anything anyway, so why bother.

No, it is none of these, and it really is hard to define. But, when you look at a child who only a short time before stared at you with leaden eyes and you see a flicker of response there; and perhaps, for the first time he or she walks to you when you say his or her name, then you have established "rapport". Or at least you are on your way.

In the Library

By Sheena Graham

LIVING IN THE OPEN; New poems by Marge Piercy
TAO MAGIC; Chinese art of the occult, by Laszlo Legeza
ANIMAL LIBERATION; New ethics for a treatment of animals, by Peter Singer
HANSELS AND GRETELS; Studies of children in institutions for the mentally retarded, by Dorthea Braginsky
CHILDREN OF THE COUNTER CULTURE; How the lifestyle of America's flower children has effected an even younger generation, by John Rothchild and Susan Wolf
CRAZY SALAD; Selection of twenty five short stories, by Nora Ephron

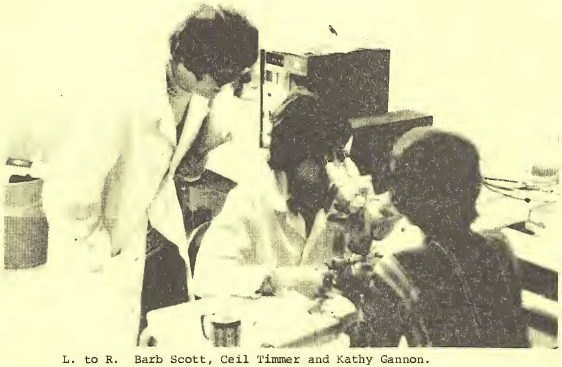


EDITORIAL
By Steve Marks

The other day as I was crossing the street in front of the Administration Building, I looked up and saw my life pass before my very eyes. What happened was that someone driving a very fast car must have mistook me for something other than human because they didn't seem to care if I was to become a hood ornament or not. Now, I have never regarded myself as the most likeable person I have ever met, but I didn't think anyone had put out a contract on me. Therefore, I was left with only one conclusion; someone was late for work and had to get there fast!

This brings me to the point of my essay. Many observe the speed limit on grounds, some don't. I'm occasionally guilty, as I am sure everyone is, but that's not the point. There are those who live here that aren't as mobile as the rest of us and they might be the brunt of a horrible accident some day. I hope this never happens, but all it takes is once.

Our Lab . . .



L. to R. Barb Scott, Ceil Timmer and Kathy Gannon.

By Steve Marks

Not long ago, I was reading an article on Medical Laboratory Technology. Now, I have always known (and taken for granted) that every hospital has a Medical Lab, but until reading this article I had absolutely no idea what a vital service a lab provides. This prompted me to visit Mrs. Barbara Scott, BRS&H's Laboratory Technologist Supervisor. During the course of our conversation, I became aware that our Lab has many interesting functions. The following are the highlights of our conversation.

Steve: Generally, what services are provided by the Hospital Lab?

Barb: The Laboratory provides all routine blood and urine tests in addition to a comprehensive program of monitoring residents' drug levels. We maintain a total quality control program. This means that every test that is run in the program (e.g., urine, blood sugar, etc.) is checked and re-checked for accuracy from known samples. We are also tested monthly by the Cap Survey Testing Firm which continually evaluates us and our program.

Steve: Approximately how many lab tests do you run each month?

Barb: One thousand to 1,200 tests. This work is divided among three Lab Technicians. In computing work load per capita, we do more tests than any other Lab in the state. This includes both private and public facilities.

Steve: How can you do this?

Barb: Well, you have to look at the personnel that we have here. The amount and, more importantly, the quality of work that we do is the direct result of a highly competent, well educated team that works well together.

Steve: Which tests are run most often?

Barb: I think I would have to say drug levels. They are routinely done on all residents on seizure medications, as well as at any time of illness.

Steve: What is the most interesting case that you have ever encountered here?

Barb: I can remember one particular resident who lived for two full years, when all lab tests showed that a normal person would not be living.

Steve: What research projects are currently being undertaken?

Barb: We have just been contacted by a California hospital to take part in establishing a consulting service for people with uric acid abnormalities.

Steve: What do you have planned for the near future?

Barb: More in-service training and workshops, a JCAH Survey and continued concern for the best possible service for our residents.

Welcome Rufino

Our new Staff Physician, Rufino V. Santos, comes to us from Western State Hospital, Staunton, Virginia. During his four and a half year stay there he worked in a variety of different areas, including pathology, psychiatry, alcohol treatment, mental retardation and behavior modification. His wealth of experience combined with his medical background makes him extremely well prepared for his new position.

Dr. Santos was born in Malabon, Metro Manila, Philippines in 1936. He moved to Manila in 1953 and began studying for his B.S. in Medical Science at Far Eastern University. He received his degree in 1957 and shortly thereafter was accepted at the College of Medicine at Manila Central University. There he graduated in 1962, after a years internship at the Quezon City Veterans' Memorial Hospital.

Before coming to the United States, he worked in the Philippines for seven years as an Industrial Physician and General Practitioner. During this time he became discouraged with the violence, class struggles and rising inflation that his country was going through. He applied for, and was granted in January, 1970, a visa for entering the United States. On May 3, 1970, he arrived in this country with the promise of a job as a House Physician (similar to our Staff Physician), at Lincoln Memorial Hospital in Columbus, Ohio. But, because of his long wait for a visa, it was filled by the time he had arrived. In mid-June, he accepted a position in the Pathology Department at Albert Einstein Medical Center in Philadelphia, Pennsylvania. In 1971, he moved to Boston and became the House Physician at Jewish Memorial Hospital. After a years work there, he became the Attending Physician at Western State Hospital.

He and his wife, Linette, were both naturalized as U.S. citizens this past year. They have three children, Lyn, Betsy and Richard and are currently living on-grounds in the former superintendent's house.

According to Dr. Taubenberger, Clinical Director, "Dr. Santo's varied previous experience in institutional medicine makes him a real asset to our facility. Also, he has established excellent cooperation with my staff as well as my medical consultants."

Union News

By Sharon Donaldson

The 45th Legislature is getting into full swing. The following are some of the Bills you should be aware of and follow, since they could affect us all.

Contribution to Insurance for State Employees: HB 183, HB 170, HB 346.

Another Bill of interest is HB 293 which provides a change from ¼ pay for sick time accumulated upon termination to ½ pay. All of the above pertain to employee benefits.

HB 772 deals with Revision of Developmental Disabilities Services and Facilities Act.

HB 658--An Act relating to the payments for Care of Residents of Institutions, etc.

These bills were presented in hearings Wednesday, February 17th. The final day for bills to be submitted to the House is Wednesday, February 23rd.

Actors Needed

By Coyote

The basic ingredients to any performance is the actor, plain and simple, all else is garnish.

Remember, "Because Their Hearts Were Pure" last summer at the High Country Saloon in Basin? It was two sold out nights of rip-roaring fun.

Well, the people who put that show together are itching for another and are looking for more interested people (like you) to join in the excitement.

If you have ever had the least hankering of a stitch to see what this show biz is about, then this just may be it. Some fine ideas for shows have been suggested, but we need that basic ingredient, you!

If you think you would be interested, just call me, Coyote, and I can fill you in.

Sports Facts

Guess who?...

Most people believe that George Blanda has played more consecutive seasons of pro football than anyone else. Not true, although he has played more pro football seasons than anyone, Earl Morrall has the record for the most consecutive years. Blanda played every year from 1949 through 1958, but sat out 1959, and then played every year from 1960 through 1975. Therefore, the most consecutive years he has played are 16. Meanwhile, Earl Morrall has played pro football every year from 1956 through 1975 for a total of 20 consecutive years.

Here's an interesting sports fact. Did you know that a 12 year old boy once won a gold medal at the Olympics? Bernard Malivoire of France broke the record as the youngest person ever to win an Olympic gold medal. He did it by serving as coxswain in a rowing event.

The youngest girl ever to win a gold medal was 13 year old Marjorie Gestring of the U.S. She won a swimming event in the 1936 Olympics.

The Trading Post

FOR SALE-IN BOULDER
Three bedroom house, basement, full lot, appliances included. Call Barb Seybert at 225-3814.

FOR SALE
AKC registered, Labrador Retriever puppies. Both parents are pedigree black Labs and are good hunters and aggressive retrievers. Both have good bloodlines with 24 field trial champions listed in the last five generations of their pedigrees. $125.00 each. Contact Tim Plaska 225-3221.

FOR SALE
Used White zig-zag dress maker in good condition. Call Jane Spethman after 5:00 p.m. at 225-3608.

WANTED TO BUY
A twin size or youth bed, including mattress. Phone 225-3803.

FOR SALE
Fender Bass guitar and a 1964 International Travelall. Call Terry at 225-3243 after 3:00 p.m.

What is Cerebral Palsy?

(Editor's Note: This was taken from the November Issue of the State of Illinois, D.D. Directions. This is the first of a two part sequence.)

What is Cerebral Palsy?

Cerebral Palsy is the general term applied to a group of permanent disability symptoms resulting from damage to the developing brain that may occur before, during or after birth and that results in loss or impairment of control over voluntary muscles.

Anyone may be affected by the condition, regardless of race, economic standing or environment, since anything which can damage brain tissue can cause cerebral palsy.

An estimated 750,000 persons have cerebral palsy. About 15,000 babies are born with cerebral palsy annually, or one newborn in every 200 live births.

The Characteristics of Cerebral Palsy

Prognosis: Cerebral palsy cannot be "cured" but it is neither progressive nor fatal. For the most part it is not inherited.

Characteristic of cerebral palsy is the presence of motor involvement. Motor involvements include awkward or involuntary movements, poor balance, irregular gait, poorly articulated speech, tightness of muscles - all of which are caused by the brain's inappropriate regulation of movements.

Although cerebral palsy denotes a person with a motor handicap, its relationship to the brain almost inevitably results in other types of handicaps as well.

a. Mental Retardation: from 50 to 75 percent of children and adults with cerebral palsy are retarded intellectually to some degree; mostly with mild to moderate subnormalities;

b. Convulsions: which may occur initially at any age;

c. Speech Problems: especially poor articulation (a result of faulty coordination of the speech musculature) affects 70 percent or more persons with cerebral palsy;

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d. Visual Disorders: including an eye turning in or out (strabismus) or visual impairment affecting 35 percent of those with cerebral palsy;

e. Hearing Impairments: reported in 20 percent of persons with cerebral palsy when the disorder is due to jaundice following birth;

f. Learning Disabilities: conceptual and perceptual problems and language disorders may occur in children with generally average or above average intelligence;

g. Behavior Disorders: brain damage may result in less than normal adaptability to stress and anxiety; however, a major effect is poor parent-child relationships;

h. Dental Abnormalities: insufficient build-up of tooth enamel during prenatal development makes the person with cerebral palsy especially susceptible to dental caries and "irregular" positioning of teeth;

i. Contractures: joints such as the ankle, elbow or wrist become permanently fixed in an abnormal or deformed position because of the excessive and unnatural pull of muscles around the joint.

The Major Types of Cerebral Palsy

There are six major types of cerebral palsy, as follows:

a. Spasticity: muscle spasms the most frequently occurring motor symptom of cerebral palsy;

b. Athetosis: marked by constantly recurring, slow involuntary writhing movements of the arms and legs;

c. Ataxia: walking like a drunken person;

d. Tremor: similar to the fine tremulousness seen in adults who have Parkinsonism;

e. Rigidity: muscles contract slowly and stiffly, leading to clumsiness;

f. Mixed: two or more of the above.

In some persons with cerebral palsy, the symptoms are so slight that except for some clumsiness they may be unnoticed. Others may be extensively handicapped, in a wheelchair and require assistance with the most basic activities of daily living, such and feeding and toileting.

The Main Causes of Cerebral Palsy

1. Prematurity.
2. Anoxia (difficulty of the newborn in breathing).
3. Complications of labor or delivery.
4. Jaundice (a yellowing of the skin) of the newborn due to Rh or other blood type incompatibilities, infection or prematurity.
5. Infections of the brain, such as meningitis or encephalitis.
6. Poisonings, such as lead or other heavy metals or drugs.
7. Accidents resulting in head trauma.

In more than 1/3 of affected individuals, the cause at present is unknown.

The Treatment Goals

The general treatment goal for the individual with cerebral palsy is to help him function as optimally as he can within the limits of his basic handicap. While it may be impossible to alter the extent of his motor incoordination, it is possible to train him to get the "most out of what he has." At present, therapists are using certain treatment regimes geared specifically to improving the lack of coordination. There is sufficient evidence to know whether the improvement frequently seen is solely the result of treatment or simply the result of growth and maturation.

Drug therapy is also being used to control some of the symptoms of cerebral palsy.

Another major treatment objective is the prevention of the secondary handicaps listed above. If this is impossible, then the aim is to modify the harmful effects these conditions cause.

(Editor's Note: The next issue of the Brush-Up will include the conclusion of, "What is Cerebral Palsy?"

All contributions to the "Brush-Up" will be appreciated. Please send your articles, letters and classified ads to Editor, Administrative Affairs, Boulder River School and Hospital, 225-3311, ext. 260.

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